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ABSTRACT

This document updates a recent report by the General Accounting Office (GAO) which compared Medicare catastrophic health insurance proposals. The update includes H.R. 2470, as passed by the House of Representatives and S. 1127, as reported by the Senate Committee on Finance. An introduction explains the roles of Medicare, Medicaid, the Veterans Administration, Medigap insurances, and out-of-pocket expenses in paying for catastrophic health care. The GAO analyses of the potential effects of S. 1127 and H.R. 2470 on out-of-pocket costs are described and the extent to which 12 other legislative proposals would fill remaining gaps in Medicare coverage is highlighted. Analyses are presented in five tables that show the out-of-pocket liability for Medicare beneficiaries currently and under the pending bills for: (1) inpatient hospital services; (2) nursing home care; (3) home health care; (4) Medicare part B services; and (5) services not covered by Medicare. Each table is accompanied by text which includes discussions of the services, Medicare coverage, out-of-pocket expenses, legislative proposals, and GAO comments. A sixth table compares the catastrophic expense protection limits established in the bills. Financing and costs are discussed and presented in the final table. The report concludes that either H.R. 2470 or S. 1127, if enacted, would represent an important step in increasing the health insurance coverage available to the elderly, but that significant gaps would remain. (NB)

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United States General Accounting Office

GAO

Briefing Report to the Chairman, Select Committee on Aging, House of Representatives

October 1987

MEDICARE

Comparison of Catastrophic Health Insurance Proposals--An Update

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United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-226390

October 16, 1987

The Honorable Edward R. Roybal
Chairman, Select Committee on Aging
House of Representatives

Dear Mr. Chairman:

This briefing report updates our recently issued report[1] comparing Medicare catastrophic health insurance proposals to include H.R. 2470, as passed by the House on July 22, 1987 and S. 1127, as reported by the Senate Committee on Finance on July 27, 1987. A future report will discuss the catastrophic health insurance proposals affecting those under age 65.

BACKGROUND

Public programs financed two-thirds of the elderly's estimated $120 billion in personal health care expenditures in 1984. Medicare, which provides health insurance benefits for most individuals age 65 and older, pays about half of the elderly's total health care bill. Implemented in 1966 under title XVIII of the Social Security Act, Medicare comprises the Hospital Insurance Program (part A) and Supplementary Medical Insurance Program (part B). Medicare has a uniform eligibility and benefit structure and makes protection available without regard to income or assets.

Other major government sources of funds for the elderly's personal health care are Medicaid, a federal/state program of medical assistance to certain categories of low-income persons, and the Veterans Administration (VA), which provides care through its hospitals, outpatient clinics, and VA-operated and community nursing homes. In 1984, Medicaid paid about 13 percent of the elderly's health care bills; VA paid about 3 percent.

Even with government programs, the elderly can face high out-of-pocket health care costs. According to a December 1986 report sponsored by the American Association of Retired Persons,[2]

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[1] Medicare: Comparison of Catastrophic Health Insurance Proposals (GAO/HRD-87-92BR, June 19, 1987).

[2] ICF Incorporated, Medicaid's Role in Financing the Health Care of Older Women, December 1986, p. 36.

married couples over age 65 averaged about $3,000 in out-of-pocket health care costs in 1986.

In November 1986, the Secretary of Health and Human Services (Otis R. Bowen, M.D.) reported[3] to the President on catastrophic illness expenses. Subsequently, the administration submitted a proposal to the Congress, and others have introduced bills to relieve the elderly from the burden of catastrophic health care expenses.

METHODOLOGY

We updated our June report for subsequent actions by the House and Senate on H.R. 2470 and S. 1127, focusing on their potential effect on Medicare beneficiaries' out-of-pocket health care expenses and the financing mechanisms proposed. We incorporated this with our previous work which consisted of (1) reviewing GAO and other reports to identify the types and amounts of out-of-pocket expenses incurred by the elderly, (2) reviewing Medicare law and regulations to determine beneficiaries' out-of-pocket liability for covered services, (3) reviewing minimum coverage requirements for Medigap policies to determine how they affect out-of-pocket costs, and (4) analyzing 12 other catastrophic coverage bills introduced during the 100th Congress to determine how they would address the major types of catastrophic health care costs the elderly incur.

RESULTS IN BRIEF

Both the House-passed and Senate Committee on Finance-approved bills provide expanded coverage through changes to parts A and B. Both bills place an upper limit on beneficiary liability for Medicare deductibles and coinsurance, making unnecessary a number of the coverage items in existing Medigap policies purchased by many elderly from private insurers. Beneficiaries, including lower income individuals who may not be able to afford Medigap premiums, would pay increased part B premiums. Medicare beneficiaries' would also pay income-related supplemental premiums through the federal income tax system.

According to the Congressional Budget Office, neither bill would generate sufficient premium receipts (income-related and part B premiums) to cover the costs of the new Medicare benefits without ad hoc premium increases. It estimates that benefit

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[3]Department of Health and Human Services, Catastrophic Illness Expenses, Washington, D.C., November 1986.

costs paid out will amount to $32.4 and $22.1 billion over the next 5 years for the House and Senate Finance bills, respectively.

S. 1127 and H.R. 2470 would establish a catastrophic limit above which the beneficiary would no longer be liable for certain Medicare deductibles and coinsurance. This is the standard method of providing catastrophic coverage in health insurance programs. Of course, having a fixed dollar catastrophic limit affects beneficiaries in different ways; that is, lower income beneficiaries would have to spend a higher percentage of their income on health care before they reached the limit than would higher income beneficiaries. Both S. 1127 and H.R. 2470 address this with supplemental premiums relating the amount beneficiaries pay for catastrophic coverage to their incomes.

H.R. 2470 and S. 1127 would essentially cap physician services and hospital care, which account for about 27 percent of the out-of-pocket costs incurred by the elderly. The two bills would also cap skilled nursing facility coinsurance during the first 150 days. H.R. 2470 would add Medicare coverage for two new services--prescription drugs and in-home personal care. Beneficiaries would pay a $500 deductible and 20-percent coinsurance for prescription drugs. A chronically dependent individual could receive up to 80 hours per year of in-home personal care with 20-percent coinsurance.

Both proposals would still leave the elderly at risk of high out-of-pocket costs. First, Medicare provides only minimal coverage of long-term care services for the chronically ill elderly. Those needing such care would continue to be at risk for potential annual out-of-pocket costs for nursing home care (about $24,000 per year) and home health care (about $18,000 per year for daily visits).

Second, Medigap policies primarily cover only the deductibles and coinsurance for Medicare-covered services rather than expand coverage to other services; therefore, neither they nor S. 1127 would relieve the elderly from out-of-pocket costs for services not covered by Medicare. H.R. 2470 would provide some relief through the added coverage of prescription drugs and in-home personal care.

And finally, according to the Bowen report, for the estimated 7 million beneficiaries who incurred from $2,000 to $4,999 in out-of-pocket costs for Medicare-covered services in 1983, 32.4 percent of those costs were for physician charges above the Medicare-approved rate. Similarly, for the estimated 1 million

beneficiaries incurring $5,000 or more in out-of-pocket costs for Medicare-covered services, 21.9 percent of those costs were for physician charges above the Medicare-approved rate. Because of increases in the percentage of physicians accepting the Medicare determination of reasonable charges as payment in full, these percentages of out-of-pocket costs probably have decreased somewhat since 1983. Neither S. 1127 nor H.R. 2470 would relieve Medicare beneficiaries of these charges in excess of Medicare-approved rates by physicians not accepting the Medicare-determined reasonable charge. Although the majority of Medicare beneficiaries have Medigap policies to pay the coinsurance for part B services, Medigap policies generally will not pay for charges above the Medicare-approved rate.

Either bill, if enacted, would represent an important step in increasing the health insurance coverage available to the elderly, but as discussed above, significant gaps would remain. The other 12 legislative proposals would address some of these gaps. However, providing further relief under S. 1127 or H.R. 2470 to those elderly who incur high out-of-pocket health care expenses would obviously increase Medicare costs.

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As requested by your office, we did not obtain agency comments on this briefing report. Unless you publicly announce its contents earlier, we plan no further distribution until 5 days from the report's issue date. At that time, we will send copies to other congressional committees having jurisdiction over the matters discussed in the report, the Secretary of Health and Human Services, and other interested parties.

If you have any questions, please call me on 275-6195.

Sincerely yours,

Michael Zimmerman
Senior Associate Director

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Abbreviations

AARP	American Association of Retired Persons
GAO	General Accounting Office
ICF	intermediate care facility
SNF	skilled nursing facility
VA	Veterans Administration

MEDICARE: COMPARISON OF CATASTROPHIC HEALTH INSURANCE PROPOSALS--AN UPDATE

INTRODUCTION

In September 1986 we reported[1] that spending for personal health care for the elderly almost tripled between 1977 and 1984, increasing from $43 billion to a projected $120 billion. By 1984, persons age 65 and over accounted for one-third of all personal health care expenditures nationally. Public sources--Medicare, Medicaid, and the Veterans Administration (VA)--financed about two-thirds of the 1984 personal health care expenditures of the elderly.

Medicare

Medicare is a federal program (authorized effective on July 1, 1966, by title XVIII of the Social Security Act) that assists most of the elderly and some disabled people in paying for their health care. The program provides two basic forms of protection:

-- Part A, Hospital Insurance, which is financed primarily by Social Security payroll taxes, covers inpatient hospital services, posthospital care in skilled nursing facilities (SNFs), hospice care, and care provided in patients' homes. In fiscal year 1985, Medicare part A covered 30.6 million enrollees, and benefits amounted to about $46 billion. About $43 billion (94 percent) of part A expenditures were for inpatient hospital services.

-- Part B, Supplementary Medical Insurance, which is a voluntary program financed by enrollee premiums and federal general revenues, covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services. In fiscal year 1985, Medicare part B covered 30 million enrollees, and benefits totaled about $21.9 billion.

Although the scope and coverage of medical services under Medicare is broad, it requires considerable beneficiary cost sharing, and there is no catastrophic limit on medical expenses paid by the beneficiary. Additionally, some health care expenses are not covered at all, such as outpatient drugs; vision, hearing, and dental care; and care provided in intermediate or custodial care facilities.

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[1] An Aging Society: Meeting the Needs of the Elderly While Responding to Rising Federal Costs (GAO/HRD-86-135, Sept. 30, 1986), pp. 34-35.

Medicaid

Medicaid is a grant-in-aid program under which the federal government pays from 50 to 78 percent of state costs for medical services provided to low-income people unable to pay for their care. The program, authorized by title XIX of the Social Security Act, began on January 1, 1966.

Within broad federal guidelines, each state designs and administers its own Medicaid program. In May 1987 we reported[2] that this results in significant interstate variations in eligibility requirements and benefits provided.

Medicaid regulations require participating states to cover 10 basic services for all categorically needy recipients, including inpatient and outpatient hospital services, laboratory and X-ray services, services in a SNF, home health services, and physician's services. States can also offer any mix of specified optional services, such as home and community-based services; services in an intermediate care facility (ICF); and prescribed drugs, dentures, and eyeglasses.

In recent years, the number of Medicaid recipients age 65 and over was estimated to range from 3.5 to 4 million, most of whom were also covered by Medicare. In 1984, state and federal Medicaid expenditures for the elderly totaled an estimated $15.3 billion, primarily for nursing home care.[3]

Veterans Administration

VA, authorized under title 38 of the U.S. Code, operates the largest health care delivery system in the United States. In addition to providing care in VA hospitals, outpatient clinics, nursing homes, and domiciliaries, VA awards contracts and grants to provide health care services in non-VA hospitals, community nursing homes, and state veterans' homes. In 1984, VA had about $3.3 billion in health expenditures for the elderly.

Before 1986, any honorably discharged veteran age 65 or over was eligible for free care at VA facilities on a space-available basis. In 1986, the Comprehensive Omnibus Budget Reconciliation Act of 1985 eliminated the separate basis of eligibility for

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[2]Medicaid: Interstate Variations in Benefits and Expenditures (GAO/HRD-87-67BR, May 4, 1987), p. 7.

[3]Daniel R. Waldo and Helen C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the U.S.: 1977-1984," Health Care Financing Review, Vol. 6, No. 1, Fall 1984, pp. 23-24.

veterans age 65 and older and established three categories of eligibility based on income for veterans with no service-connected disabilities.

Medigap

The majority of elderly people purchase some type of private supplemental insurance (commonly called Medigap insurance) to cover all or part of the deductible and coinsurance amounts not covered by Medicare. However, the percentage of the population with Medigap coverage increases as family income increases (see figure 1). About 44 percent of the elderly with family incomes below $5,000 have Medigap coverage compared to 87 percent of those with incomes of $25,000 and over. More importantly, about 30 percent of those with incomes below $9,000 have neither Medicaid nor Medigap coverage, placing them at the greatest risk from high out-of-pocket costs.

Section 1882 of the Social Security Act, added by Public Law 96-265, June 9, 1980, established standards for Medigap policies requiring that they provide at least a minimum level of coverage and include certain provisions. The law also set minimum expected levels of benefit payments--called loss ratios. Medigap policies sold to individuals must have an anticipated return of benefits to policyholders of at least 60 percent of the premiums collected and 75 percent for policies sold to groups.

In October 1986 we reported[4] that Medigap policies sold by commercial insurers that had more than $50 million in premiums and Blue Cross/Blue Shield plans generally met the loss ratio requirements of section 1882, i.e., that about 60 cents of every premium dollar be returned as benefits or added to reserves. However, over 60 percent of the commercial insurance policies with premiums under $50 million in 1984 did not meet these requirements.

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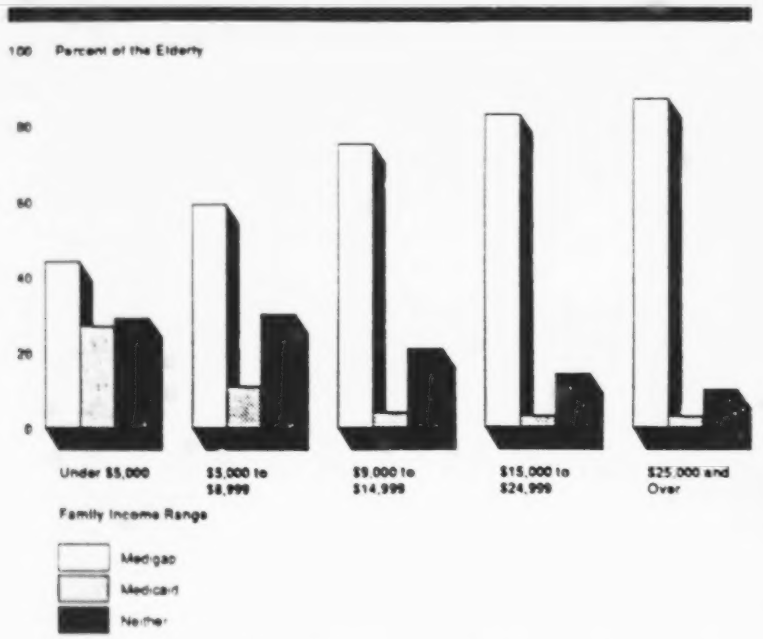
[4]Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 17, 1986), p. 3.

Figure 1: Medigap Coverage for the Elderly Population by Family Income (1986)



Source: Based on Congressional Budget Office data reported in ICF Incorporated, "The Effects of Variations in Medicaid Programs on Older Women," Washington, D.C., December 1986, p. 28.

About 200,000 elderly persons also purchase private long-term care insurance policies to protect themselves against financial loss incurred primarily when nursing home care is needed. These policies are not technically Medigap policies; therefore, they are not subject to federal regulations under section 1882 of the Social Security Act. In May 1987 we reported[5] that some states have taken action to regulate this new and rapidly developing market, and we suggested that the Congress consider enacting federal legislation to balance insurer experimentation with innovative insurance products and consumer protection.

Out-of-Pocket Costs

"Catastrophic" health care expense may be defined in terms of out-of-pocket expenses relative to income or of an absolute dollar amount (such as the $500 to $2,000 caps proposed by the various bills). In a November 1986 report on catastrophic illness expenses

[5]Long-Term Care Insurance: Coverage Varies Widely in a Developing Market (GAO/HRD-87-80, May 29, 1987), p. 5.

(the Bowen report),[6] the Secretary of Health and Human Services described them as expenses that cannot be borne by individuals and families without having to significantly change their life style or drastically modify their expectations of living standards in the future. We have used the term catastrophic in this report in describing examples of health care expenses that may or may not be considered catastrophic depending on the definition used.

According to a December 1986 report sponsored by the American Association of Retired Persons (AARP),[7] the out-of-pocket health care expenditures for married couples over age 65 averaged about $3,000 in 1986, including health insurance premiums. According to the Congressional Budget Office,[8] the amounts different persons pay in out-of-pocket costs differ by orders of magnitude. The distribution of copayments, for example, would be very uneven in 1989 under current law, with 30 percent of Medicare enrollees incurring little or no costs, while 0.5 percent with long or multiple hospital stays would incur average out-of-pocket costs of about $8,000.

According to the Bowen report, in 1984, of the elderly's out-of-pocket expenditures, nursing home expenditures accounted for 41.6 percent; physician services, 21.4 percent; hospital care, 5.6 percent; and other care, 31.3 percent (including services not covered or partly covered by insurance and long-term care services other than nursing home care).

The sources of the elderly's out-of-pocket costs change as total out-of-pocket expenses increase. Rice and Gabel[9] reported that for the elderly subject to very high financial liabilities (more than $2,000), nursing home care is the overwhelming cause (see figure 2).[10] On the other hand, the elderly with relatively low out-of-pocket costs spent their money primarily on physician,

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[6]Department of Health and Human Services, Catastrophic Illness Expenses, Washington, D.C., November 1986, p. 15.

[7]ICF Incorporated, Medicaid's Role in Financing the Health Care of Older Women, Washington, D.C., December 1986, p. 39.

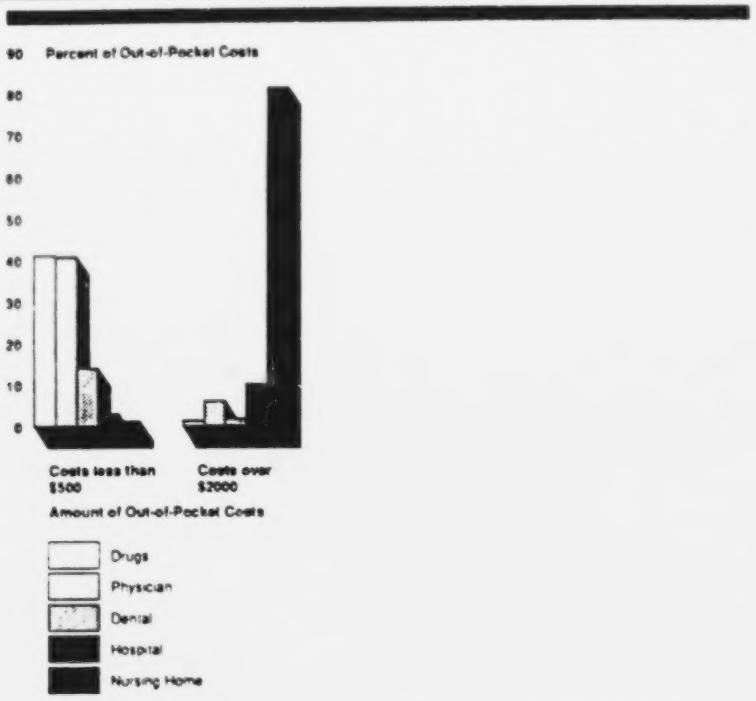
[8]U.S. Congressional Budget Office, A Comparison of Selected Catastrophic Bills, Washington, D.C., August 3, 1987, p. 14.

[9]Thomas Rice and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," Health Affairs, Vol. 5, No. 3, Fall 1986, p. 16.

[10]Their analysis was based on data from the 1980 National Medical Care Utilization and Expenditure Survey and the 1976-77 National Nursing Home Survey, projected to 1980, the most recent national data available.

drug, and dental services. Specifically, 95 percent of the out-of-pocket costs for those spending $500 or less were attributed to those three types of services.

Figure 2: Out-of-Pocket Costs by Type of Service (1986)

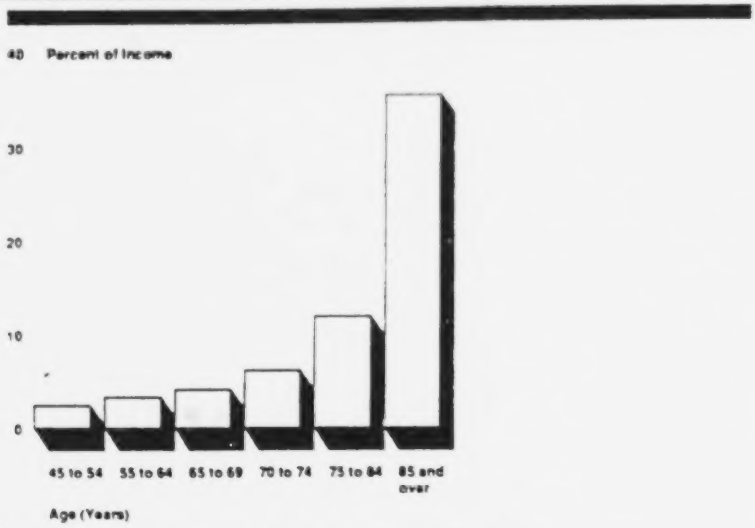


Source: Thomas Rice and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," Health Affairs, Vol. 5, No. 3, Fall 1986, p. 16

The AARP report also showed that out-of-pocket expenditures as a percentage of income increase with age (see figure 3). For example, the report notes that out-of-pocket expenditures (excluding health insurance premiums) will average about 8.3 percent of household income for all elderly woman households[11] compared to about 2.8 percent among the 45- to 64-year-old group. Particularly at risk are the elderly age 85 and over. Of this elderly population, nearly 70 percent are women who spend an average of over 35 percent of their income on medical expenses.

[11]Single women age 65 or older and married couples with a woman age 65 or older.

Figure 3: Out-of-Pocket Health Expenditures for All Older Women as a Percentage of Income, by Age (1986)



Note: Health expenditures exclude health insurance premiums.

Source: ICF Incorporated, "Medicaid's Role in Financing the Health Care of Older Women," Washington, D.C., December 1986, p. 44.

Objectives, Scope, and Methodology

The Chairman of the House Select Committee on Aging asked us to update our recent report[12] comparing catastrophic health insurance proposals for subsequent actions by the House and Senate. We analyzed the potential effects of S. 1127 and H.R. 2470 on out-of-pocket costs, concentrating on the provisions that would have the greatest impact on catastrophic expenses. Additionally, we updated the report to reflect Congressional Budget Office estimates of beneficiary deductibles and coinsurance for 1989 and the latest projections of the costs of H.R. 2470 and S. 1127.

We added the updated information to our previous work, which consisted of (1) reviewing GAO and other reports to identify the types and amounts of out-of-pocket expenses incurred by the elderly, (2) reviewing Medicare laws and regulations to determine beneficiaries' out-of-pocket liability for covered services, (3) reviewing minimum coverage requirements for Medigap policies to determine how they affect out-of-pocket costs, and (4) evaluating 12 other catastrophic coverage bills introduced during the 100th Congress to determine how they would address the major types of catastrophic health care costs the elderly incur. We highlight the

[12] Medicare: Comparison of Catastrophic Health Insurance Proposals (GAO/HRD-87-92BR, June 19, 1987).

extent to which the other 12 legislative proposals, if enacted, would fill remaining gaps in Medicare coverage.

The bills reviewed and their primary sponsors were:

S. 1127--Bentsen (approved on May 29, 1987, by the Senate Committee on Finance and reported on July 27, 1987).
H.R. 2470--House bill originally sponsored by Stark (passed on July 22, 1987, by the House and received in the Senate on July 24, 1987).
S. 592--Dole (administration bill).
H.R. 1245--Michel (administration bill).
S. 210--Kennedy.
S. 454--Sasser.
S. 754--Dole.
H.R. 65--Pepper.
H.R. 200--Roybal.
H.R. 784--Bonker.
H.R. 1182--Regula.
H.R. 1280--Stark.
H.R. 1281--Stark.
H.R. 1930--Roybal.

Our work on this update was done from August through October 1987 and covered legislative actions that took place through October 13, 1987.

Our analysis is presented in five tables that show the out-of-pocket liability for Medicare beneficiaries currently and under the pending bills for (1) inpatient hospital services, (2) nursing home care, (3) home health care, (4) Medicare part B services, and (5) services not covered by Medicare. In a sixth table, we compare the catastrophic expense protection limits established in the bills. Finally, we discuss financing proposed by the administration and in the bills reported out of the Senate Committee on Finance and passed by the House.

Table 1:
Medicare Beneficiary's Liability for Part A Inpatient Hospital Expenses (1989)

	Deductible per		Daily coinsurance		Days in excess of lifetime reserve	Over 190 lifetime psychiatric days	Blood deductible per	
	Spell of illness	First hospitalization per year	61st to 90th day	Lifetime reserve days (60)			Spell of illness	Year
Current Medicare law	$580		$145	$29	All	All	1st 3 pints	
Medigap, maximum out-of-pocket costs	$580		None	None	10%[a]	All	None	None
Bill #								
S. 1127[b]		$580	None	None	None	All		1st 3 pints
H.R. 2470		$580	None	None	None	All		1st 3 pints
S. 592[c]	$580[d]		None	None	None	All	1st 3 pints	
H.R. 1245[c]	$580[d]		None	None	None	All	1st 3 pints	
S. 210	$580[e]		None	None	None	All	1st 3 pints	
S. 494	None	None	None	None	None	All	None	None
S. 754		$580	None	None	None	All	None	None
H.R. 65	None	None	None	None	None	All	None	None
H.R. 200	None[f]	None[f]	f	f	f	f	f	f
H.R. 784	$580		None	None	None	All	1st 3 pints	
H.R. 1182	$580[d]		None	None	None	All	1st 3 pints	
H.R. 1280[g]		$580	None	None	None	All		1st 3 pints
H.R. 1281[g]	$580		$145	$290	All	All	1st 3 pints	
H.R. 1930		$580	None	None	None	All		1st 3 pints

[a]Medigap policies pay at least 90% of covered charges up to 365 days after the insured has exhausted his or her Medicare benefits.

[b]The liability shown is for beneficiaries enrolled in both parts A and B. For beneficiaries enrolled in part A only, liability would be the same as shown for the current Medicare law.

[c]Administration bill.

[d]The beneficiary would be liable for no more than two inpatient hospital deductibles per year.

[e]Before the 60th day of care after the second hospitalization in any calendar year, the bill would pay for the first 10 days of hospital care not paid for by any other government program.

[f]The bill eliminates deductibles, but requires 20% coinsurance until the beneficiary reaches the $500 coinsurance limit for all services covered by this bill.

[g]Although we discuss the two bills separately, H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) comprise a legislative package for catastrophic protection. H.R. 1280 and H.R. 1281, when combined, require a $580 deductible for the first hospitalization per year with no inpatient hospital coinsurance.

INPATIENT HOSPITAL CARE

Definitions

Inpatient hospital care includes room and board; regular nursing services; special care unit services, such as intensive care or coronary care; drugs furnished by the hospital; blood transfusions; laboratory tests; X-rays and other radiology services; medical supplies, such as surgical dressings; use of appliances, such as a wheelchair; operating and recovery room costs, including anesthesia services; rehabilitation services, such as physical or speech therapy; and psychiatric care.

Deductibles are the amount of covered charges that a beneficiary must pay before his or her health plan pays any benefits. Deductibles may apply either to a calendar year or on a per admission basis.

Coinsurance is the fixed percentage or amount of covered medical charges that the beneficiary must pay.

Medicare Coverage

Medicare part A, hospital insurance, covers inpatient hospital services on the basis of a "spell of illness." For any benefit period, part A pays for all covered services for the first three pints of blood used and the first 60 days of inpatient hospital care except for the inpatient deductible (currently $520 and projected to be $580 in 1989). For the next 30 days, the beneficiary is responsible for coinsurance equal to one-quarter of the deductible amount per day (projected to be $145 in 1989). Every person enrolled in part A also has a 60-day, nonrenewable, lifetime reserve for inpatient hospital care that can be drawn from if more than 90 days are needed in a spell of illness. When using the reserve days, the beneficiary is responsible for coinsurance equal to one-half of the deductible amount per day (projected to be $290 in 1989). Medicare coverage for care in a psychiatric hospital is limited to 190 days during a beneficiary's lifetime.

Out-of-Pocket Expenses

The Bowen report states that Medicare pays for more than 90 percent of expenditures for services covered under part A (which covers inpatient hospital and skilled nursing care). This left net beneficiary liabilities of about $2.9 billion in 1983.

About 65 percent of Medicare beneficiaries purchase Medigap policies. Minimum standards for Medigap policies require coverage of Medicare's part A blood deductible and coinsurance amounts for the 61st through 90th day and while the beneficiary uses his or her lifetime reserve days. Medigap policies must also cover 90 percent of covered hospital inpatient expenses for a lifetime maximum of up

to 365 days after the insured has exhausted his or her Medicare benefits.

However, for the approximately 35 percent of Medicare beneficiaries without Medigap coverage--primarily those with lower incomes--beneficiaries are responsible for Medicare inpatient deductibles, blood deductibles, and coinsurance for hospital stays over 60 days in duration. For example, for a beneficiary who is hospitalized once during a year for 90 days, the out-of-pocket expense for inpatient services would be $4,930, consisting of the $580 deductible and daily coinsurance of $145 for the 61st to the 90th day. If this beneficiary stayed longer, coinsurance would increase to $290 for each day, and the beneficiary would be using his or her lifetime reserve days. A stay of 10 more days (100 days total) would increase the total out-of-pocket expenses to $7,830. However, if this beneficiary had a Medigap policy providing the minimum required coverage, his or her out-of-pocket expenses for either the 90- or the 100-day stay would be $580 (the Medicare part A deductible).

Even with the minimum coverage required under Medigap regulations, beneficiaries would generally incur a deductible of $580 for every new spell of illness. For example, in fiscal year 1984, approximately 8,200 beneficiaries were hospitalized during four spells of illness. Using the 1989 deductible of $580, out-of-pocket expenses for four spells of illness would amount to $2,320 just for the Medicare part A inpatient deductibles. In addition, the beneficiary would be liable for the cost or replacement of the first three pints of blood received during each spell of illness.

Legislative Proposals

Both S. 1127 and H.R. 2470 would eliminate inpatient hospital coinsurance, provide unlimited inpatient days, and apply the inpatient deductible only for the first hospitalization each year rather than for each spell of illness. The blood deductible would also be applied on an annual basis rather than for each spell of illness. However, under S. 1127 these changes would apply only to Medicare beneficiaries who enroll under part B; part A only beneficiaries would retain the same benefits as currently provided. More than 95 percent of part A beneficiaries choose to enroll in part B, according to the Bowen report. The administration bills, S. 592 and H.R. 1245, also provide for unlimited inpatient days with no coinsurance, but would apply the inpatient deductible to the first two hospital admissions each year and would apply the blood deductible to each spell of illness.

GAO Comments

By eliminating coinsurance for hospital care, S. 1127, H.R. 2470, and the administration proposal would significantly reduce Medicare beneficiaries' out-of-pocket costs for hospital care. S. 1127 and H.R. 2470 would reduce out-of-pocket costs even further by limiting hospital deductibles to one per year.

Of the other legislative proposals, only S. 454, H.R. 65, and H.R. 200 would provide more comprehensive coverage. In addition to eliminating all coinsurance, S. 454 and H.R. 65 also would eliminate deductibles. H.R. 200 would eliminate the deductible and apply 20-percent coinsurance from the first day of hospitalization subject to a $500 cap on all services provided for in the bill.

All these proposals may be of particular benefit to low-income elderly who cannot afford Medigap coverage and are not eligible for Medicaid by enabling them to obtain needed coverage. Since the proposals would, to a large extent, duplicate current Medigap coverage, Medigap policies might be restructured to cover other services not provided under Medicare, such as dental care and hearing aids.

Table 2:
Medicare Beneficiary's Liability for
Posthospital Nursing Home Services (1989)

	Skilled nursing care daily coinsurance per spell of illness				
	1st to 20th day	21st to 100th day	Over 100 days	Intermediate care	Custodial care
Current Medicare law	None	$72.50	All	All	All
Medigap, maximum out-of-pocket costs	None	$72.50	All	All[a]	All[a]
Bill #					
S. 1127[b,c]	$19 daily for first 10 days each year	None	[d]	All	All
H.R. 2470[c]	$25 daily for first 7 days each year	None	[e]	All	All
S. 592[f]	None[g]	None[g]	All[g]	All	All
H.R. 1245[f]	None[g]	None[g]	All[g]	All	All
S. 210	None	$72.50[h]	All	All	All
S. 454[c]	None	None	None[i]	None	None[j]
S. 754	None	None	All	All	All
H.R. 65[c]	None	None	None[i]	None	None[j]
H.R. 200[c]	[k]	[k]	[k,i]	[k]	[k]
H.R. 784	None	$72.50	All	All	All
H.R. 1182	None	None	All	All	All
H.R. 1280[l]	$25 daily for first 7 days each year	None	[e]	All	All
H.R. 1281[l]	None	$72.50	All	All	All
H.R. 1930	$25 daily for first 7 days each year	None	[e]	All	All

[a]Medigap usually does not cover services that are not covered by Medicare.

[b]The liability shown is for beneficiaries enrolled in both parts A and B. For beneficiaries enrolled in part A only, liability would be the same as shown for the current Medicare law.

[c]The requirement that skilled nursing care be posthospital would be eliminated.

[d]After individuals with part A and part B coverage pay coinsurance for the first 10 days in a SNF, their liability for full cost does not begin until after the 150th day each year. Individuals covered under part A only are liable for full costs after the 100th day in each spell of illness.

[e]Beneficiary liability for full cost does not begin until after the 150th day each year.

[f]Administration bill.

[g]Administration bills eliminate coinsurance, but provide a maximum of 100 days skilled nursing care per year, rather than per spell of illness.

[h]After the catastrophic limit is reached, S. 210 provides payment for reasonable charges for not more than 100 days of SNF care in a calendar year after.

[i]The bill introduces unlimited days of skilled nursing care.

[j]Adult day care and home and community-based services are specifically included.

[k]The bill requires 20% coinsurance for skilled nursing and intermediate care and 25% coinsurance for custodial care until the beneficiary reaches the $500 coinsurance limit for all services covered by this bill.

[l]Although we discuss the two bills separately, H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) comprise a legislative package for catastrophic protection. H.R. 1280 and H.R. 1281, when combined, would require nursing home coinsurance of $25 daily for first 7 days each year and would then eliminate coinsurance through the 150th day. Beneficiaries would be responsible for all nursing home costs over 150 days per year.

NURSING HOME CARE

Definitions

Skilled nursing facilities provide skilled nursing and rehabilitative services to patients on a daily basis under the orders of a physician.

Intermediate care facilities provide health-related care and services to individuals who do not require the degree of care and treatment that is provided in a hospital or SNF but who, because of their mental or physical condition, require medical care in addition to room and board.

Custodial care facilities provide assistance in requirements of daily living, such as eating and bathing, which can be provided by persons without medical skills.

Medicare Coverage

Medicare's coverage of nursing home care is applicable to acute rather than chronic types of illness; therefore, Medicare will help pay for the first 100 days of skilled nursing home care after a hospitalization. Medicare will pay for the 1st to the 20th day of care. Beginning with the 21st day, the beneficiary has to pay the coinsurance rate of $65 per day through the 100th day (projected to be $72.50 per day in 1989). The beneficiary has liability for all expenses starting with the 101st day of care.

Medicare does not cover care provided in ICFs or custodial care facilities.

Out-of-Pocket Expenses

The beneficiary has liability for all expenses incurred in ICFs and custodial care facilities, daily coinsurance for care in SNFs for stays from 21 to 100 days, and all expenses for stays over 100 days. Long-term care expenses can become catastrophic in a relatively short time since nursing home expenses average about $2,100 or more a month.[13] Costs associated with long-term care over an extended period can wipe out the savings of a lifetime, and very few elderly people have financial protection for such expenses. A Massachusetts-based study by Harvard Medical School and Massachusetts Blue Cross/Blue Shield reported that 63 percent of elderly persons living alone will impoverish themselves in only 13 weeks in a nursing home. For elderly married couples, 37

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[13] An Aging Society: Meeting the Needs of the Elderly While Responding to Rising Federal Costs (GAO/HRD-86-135, Sept. 30, 1986), p. 57.

percent will become impoverished within 13 weeks if one spouse requires nursing home care.[14]

According to a December 1986 report[15] sponsored by AARP, about 1.9 million persons over age 45 were estimated to be in nursing homes in 1986, including about 23 percent of the population age 85 and older. Of this elderly population, nearly 70 percent are women who spend an average of over 35 percent of their income on medical expenses, primarily because of the high cost of nursing home care and limited Medicare and Medigap coverage.

Legislative Proposals

S. 1127 and H.R. 2470 would (1) eliminate the requirement that skilled nursing care be posthospital, (2) change skilled nursing home care from 100 days per spell of illness to 150 days per year, and (3) replace present coinsurance charges for stays between 21 and 100 days with coinsurance charges for the first few days of SNF care in each year based on the national average per diem. Regarding the latter change, in 1989, S. 1127 would require an estimated $19 daily coinsurance (15 percent of the national average per diem) for the first 10 days of skilled nursing home care each year, while H.R. 2470 would require an estimated $25 daily coinsurance (20 percent of the national average per diem) for the first 7 days each year. Under S. 1127 these changes would apply only to Medicare beneficiaries who enroll under part B; part A only beneficiaries (less than 5 percent of part A beneficiaries) would retain the same benefits as currently provided.

GAO Comments

S. 1127, H.R. 2470, and the administration-proposed changes in the coinsurance and benefit period for SNF care may have limited effect on the elderly's out-of-pocket costs because of other provisions of the Medicare law governing payment for SNF care. Many SNF patients lose their Medicare coverage because they do not qualify as requiring daily skilled care or therapy that will lead to a patient's rehabilitation. According to Rice and Gabel,[16]

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[14]House of Representatives, Select Committee on Aging. Hearing on The 20th Anniversary of Medicare and Medicaid: Americans Still at Risk. Washington, D.C., July 30, 1985, p. 35.

[15]ICF Incorporated, Medicaid's Role in Financing the Health Care of Older Women, Washington, D.C., December 1986, p. 22.

[16]Thomas Rice and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," Health Affairs, Vol. 5, No. 3, Fall 1986, p. 8.

Medicare SNF coverage lasted an average of 28 days in 1977, while the average stay lasted twice as long. They said that the "cutoffs" occurred because patients soon reached their "rehabilitation potential" and subsequently needed "maintenance therapy," which is not considered skilled care.

Eliminating Medicare coinsurance or extending days of coverage for SNF care would, therefore, not benefit such patients. Additionally, the elderly would remain at risk for out-of-pocket nursing home costs for intermediate or custodial care under S. 1127, H.R. 2470, and the administration bills. Three of the other proposals (H.R. 65, S. 454, and H.R. 200) would alleviate the problems by adding intermediate and custodial care. Adding long-term nursing home coverage to the Medicare program would, however, be costly since such services accounted for about $18 billion in out-of-pocket costs in 1984, according to the Bowen report.

Table 3:
Medicare Beneficiary's Liability for Home Health Services

	Not skilled or not intermittent	Not confined to home	Not Medicare certified
Current Medicare law	All	All	All
Medigap, maximum out-of-pocket costs	All	All	All
Bill #			
S. 1127	**All**	**All**	**All**
H.R. 2470	**All[a]**	**All**	**All**
S. 592[b]	All	All	All
H.R. 1245[b]	All	All	All
S. 210	All	All	All
S. 454	None	All	All
S. 754	All	All	All
H.R. 65	None	All	All
H.R. 200	[c]	All	All
H.R. 784	All	All	All
H.R. 1182	All	All	All
H.R. 1280[d]	All	All	All
H.R. 1281[d]	All	All	All
H.R. 1930	All[e]	All	All

[a]A chronically dependent individual may receive up to 80 hours per year of in-home personal care with 20% coinsurance. This benefit will expire at the end of calendar year 1991.

[b]Administration bill.

[c]Services of a homemaker/home health aide are provided when essential to the individual being maintained in an individual's home, but require 20% coinsurance until the beneficiary reaches the $500 coinsurance limit for all services covered by this bill.

[d]Although we discuss the two bills separately, H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) comprise a legislative package for catastrophic protection. Neither bill changes the current Medicare law regarding home health services.

[e]Includes rehabilitative and short-term personnel support services to prevent institutionalization.

HOME HEALTH CARE

Definition

Home health care is medically supervised care and treatment provided by nurses and aides in the patient's home. It includes such services as skilled nursing care, dressing changes, injections, monitoring of vital signs, physical therapy, prescription drugs and medications, nutrition services, medical social work, and medical appliances or equipment.

Medicare Coverage

Medicare home health benefits are, by law, oriented toward skilled nursing care. They are not designed to provide coverage for care related to helping with daily living needs unless the patient also required skilled nursing care or physical or speech therapy. Medicare home health services include

-- part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

-- physical, occupational, or speech therapy;

-- medical social services to help patients and their families adjust to social and emotional conditions related to the patients' health problems;

-- part-time or intermittent home health aide services;[17] and

-- certain medical supplies and appliances.

To qualify for Medicare home health care, a person must be confined to his or her residence (homebound), be under a physician's care, and need part-time or intermittent skilled nursing care and/or physical or speech therapy. According to the Health Care Financing Administration's home health agency manual, Medicare will generally pay for part-time medically reasonable and necessary skilled nursing care 7 days a week for a short period (2 to 3 weeks). The services must be furnished by a Medicare-approved home health agency under a plan of care prescribed and periodically reviewed by a physician. There are no deductibles or coinsurance for Medicare-covered home health services.

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[17]Home health aides, among other things, help patients bathe, groom, get into and out of bed, use the bathroom, take self-administered medications, and exercise.

Out-of-Pocket Expenses

Because Medicare pays the total cost of covered home health services, the elderly incur out-of-pocket expenses solely for noncovered services. We reported in December 198618 that the Medicare benefit was not designed to meet all of the elderly's home care needs. Medicare beneficiaries who are not homebound or do not require skilled nursing care on a part-time or intermittent basis must find needed assistance with their personal care needs (activities of daily living) and homemaker needs (instrumental activities of daily living) from family, friends, and other paid or unpaid caregivers. Similarly, beneficiaries whose home care needs exceed the limits of Medicare coverage must find other sources of support once their Medicare coverage ends.

Chronically ill beneficiaries who do not qualify for the limited home health benefit under Medicare can incur significant out-of-pocket costs for such assistance. The Health Care Financing Administration reported that charges by Medicare home health agencies averaged $49 per visit in 1985. Based on that cost, the elderly requiring home health services could incur annual out-of-pocket costs for home health care from about $2,500 for visits once a week to about $18,000 for daily visits.

In our December 1986 report, we analyzed data from the 1982 National Long-Term Care Survey and found that of the 3.2 million elderly with one or more limitations in their activities of daily living, about 168,000 (5 percent) were not receiving all of the assistance they needed with activities of daily living, and another 1.1 million (36 percent) needed more assistance with instrumental activities of daily living. We believe the high out-of-pocket costs of such assistance may contribute to the level of unmet need for home care assistance.

Legislative Proposals

S. 1127 would clarify the definitions of "confined to home" and "intermittent." An individual would be considered confined to home if an illness or injury restricts the beneficiary's ability to leave home without the aid of a supporting device or when leaving home is medically contraindicated. Intermittent would be defined to permit up to 21 consecutive days of home health care for all enrollees, and up to 45 days for part B enrollees within 30 days of prior hospital or skilled nursing home stays.

H.R. 2470 would define "intermittent" to permit up to 35 consecutive days of home health care. Also, from 1989 through 1991, a chronically dependent individual would be allowed to

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18Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986), p. 50.

receive up to 80 hours per year of in-home personal care with 20-percent coinsurance included in an effort to control utilization.

The two administration bills, S. 592 and H.R. 1245, would make no changes in existing Medicare coverage for home health services.

GAO Comments

Our December 1986 report cited the need for clarification of home health coverage criteria for intermittent care, homebound status, and use of home health aides. We stated that inconsistent interpretations of the criteria can result in unequal coverage of home health services for Medicare beneficiaries. S. 1127 would clarify the definition of a homebound individual. Both S. 1127 and H.R. 2470 would clarify the definition of intermittent care.

Two of the other legislative proposals would expand the basic Medicare benefit from a short-term, post-acute-care benefit to one that would more closely meet the home health needs of the chronically ill elderly. H.R. 65 would remove the requirement that an individual need skilled care on an intermittent basis in order to qualify for Medicare coverage. And, H.R. 200 would provide homemaker/home health aide services when essential to the individual being maintained in an individual's home.

If the home care benefit were expanded to relieve the elderly of the high costs of long-term health care, adequate internal controls should be established to control utilization, such as the 20-percent coinsurance that H.R. 2470 would include in its new in-home personal care benefit. Our prior work on home health care has shown that it is a difficult program to control and that expanded coverage would likely increase utilization and costs. One way to control utilization might be to expand coverage but impose coinsurance to discourage overutilization.

Table 4:
Medicare Beneficiary's Annual Liability for Part B
Medical Expenses Covered by Medicare

	Medicare-approved charges			Physician and other charges in excess of approved charges
	Deductible	Deductible for blood	Coinsurance after deductible(s)	
Current Medicare law	$75	1st 3 Pints	20%	All
Medigap, maximum out-of-pocket costs	$200	None	None[a]	All
Bill #				
S. 1127	**$75**	**1st 3 Pints**	**20%**	**All**
H.R. 2470	**$75[b]**	**1st 3 Pints**	**20%[c]**	**All**
S. 592[d]	$75	1st 3 Pints	20%	All
H.R. 1245[d]	$75	1st 3 Pints	20%	All
S. 210	$75	1st 3 Pints	20%	All
S. 454	None	None	None	All
S. 754	$75	1st 3 Pints	20%	All
H.R. 65	None	None	None	All
H.R. 200	None[e]	None[e]	[e]	None[f]
H.R. 784	$75	1st 3 Pints	None	All
H.R. 1182	$75	1st 3 Pints	20%	All
H.R. 1280	$75	1st 3 Pints	20%	All
H.R. 1281	$75	1st 3 Pints	20%	All
H.R. 1930	$75[g]	1st 3 Pints	20%	All

[a]Medigap policies can limit benefits to a maximum of $5,000.

[b]There will be a separate $500 deductible for drugs.

[c]Coinsurance will apply to new drug and in-home care benefits as well.

[d]Administration bill.

[e]The bill eliminates deductibles, but requires 20% coinsurance until the beneficiary reaches the $500 coinsurance limit for all services covered by the bill.

[f]Physicians accepting reimbursement under this proposal must accept direct payment and may not charge the beneficiary additional amounts.

[g]There would be a separate $300 deductible for prescription drugs.

MEDICARE PART B SERVICES

Definition

Medicare part B includes health care services rendered by physicians, nurse practitioners, and other health care providers in private offices, hospitals, or other settings; therapies and surgeries provided in outpatient hospital departments or emergency rooms to individuals who enter and leave the hospital in the same day; services performed by laboratories, such as diagnostic tests and procedures; and other medical services and supplies.

Medicare Coverage

Part B is a voluntary insurance program for Medicare eligibles. For those who elect to enroll, it pays 80 percent of the approved charges after the beneficiary meets a $75 deductible, for the above services.

Medicare-approved charges are based on what the law defines as "reasonable charges." The beneficiary is responsible for paying 20 percent of the Medicare-determined reasonable charge on claims where the physician or supplier has accepted assignment. For unassigned claims, the beneficiary is also liable for the difference between what the physician or supplier charges and what Medicare allows as the reasonable charge.

Approved charges for covered services are determined annually by Medicare carriers according to procedures prescribed by law. First, carriers determine the customary charge--the charge most frequently made--by providers for each separate service in the previous year. Then, the carrier determines the prevailing charge--the amount that is high enough to cover customary charges for three out of four bills--limited by an index relating physician fee increases to actual increases in the cost of maintaining their practices and to increases in general earnings. The approved charge will be the customary charge, prevailing charge, or actual charge, whichever is lowest.

Out-of-Pocket Expenses

According to the Secretary of Health and Human Services, the open-ended liability for unassigned claims for physician payment leaves beneficiaries open to risk for substantial out-of-pocket part B expenditures. The Secretary reported that in 1983, net beneficiary liabilities (not factoring in further reductions from Medigap insurance that covers coinsurance) amounted to $7.4 billion for part B services, or 33.5 percent of total part B expenditures. Moreover, part B expenses accounted for 72 percent of net beneficiary liabilities in 1983. Specifically, the part B deductible accounted for 14.3 percent and coinsurance for 35.5 percent of net beneficiary liabilities.

In addition, charges above the approved Medicare rate accounted for over 22 percent of net beneficiary liabilities. These charges would generally not be covered by Medigap policies. However, out-of-pocket costs to beneficiaries decreased between 1984 and 1985 because of the increased physician assignment rate. In fiscal year 1980, Medicare's national assignment rate was about 52 percent; by fiscal year 1984, it was 58 percent; and in fiscal year 1985, it increased to 69 percent. In effect, the increase in the assignment rate between 1980 and 1985 meant that beneficiaries were liable for about $1.6 billion less in reasonable charge reductions on unassigned claims than if the assignment rate had remained at the 1980 level.

Further, Medicare provides very limited coverage for some part B services, notably outpatient mental health treatment. Beneficiaries requiring outpatient blood transfusions are also responsible for paying for the first three pints at an approximate cost of $50 to $150 per pint.

Legislative Proposals

S. 1127 and H.R. 2470 would retain current part B deductibles and coinsurance subject to catastrophic caps established in the bills. H.R. 2470 would add reimbursement for two services not currently covered--prescription drugs (discussed in next section) and in-home personal care (discussed in previous section). Current part B deductibles and coinsurance would apply to these new services except that a separate $500 deductible would apply to the prescription drug benefit. Additionally, H.R. 2470 would expand outpatient mental health benefits from $312.50 to $1,250 per year and cap the beneficiary's part B liability in 1989 at $1,043 per person, or $2,086 per elderly couple. The administration bills propose no changes to the current part B deductibles and coinsurance but would apply them to a catastrophic cap.

GAO Comments

S. 1127, H.R. 2470, and the administration bills would not change the deductibles and coinsurance for part B services. S. 454, H.R. 65, H.R. 784, and H.R. 200 do propose to eliminate part B deductibles and/or coinsurance.

S. 1127, H.R. 2470, and the administration bills would provide catastrophic protection against part B deductibles and coinsurance through overall catastrophic limits. However, these limits would not protect beneficiaries from physician charges above the Medicare-approved rate on unassigned claims. Except for H.R. 200, which precludes physicians from charging the beneficiary additional amounts over the Medicare-approved amount, Medicare beneficiaries would continue to be liable for such out-of-pocket costs even when they meet the catastrophic limit in the proposed bills. One option

for relieving the elderly of this burden would be to require physicians to accept assignment. Such a requirement currently exists under part B only for diagnostic laboratory expenses. Mandating assignment could, however, decrease the number of physicians willing to participate in the Medicare program.

Table 5:
Medicare Beneficiary's Liability for
Medical Expenses Not Currently Covered by Medicare

	Prescription drugs	Hearing	Vision	Dental	Preventive lab tests
Current Medicare law	All	All	All	All	All
Medigap, maximum out-of-pocket costs	All	All	All	All	All
Bill #					
S. 1127	All	All	All	All	All
H.R. 2470	20% after $500 deductible	All	All	All	All
S. 592[a]	All	All	All	All	All
H.R. 1245[a]	All	All	All	All	All
S. 210	All	All	All	All	All
S. 454	All	None[b]	None[b]	None[b]	None[b]
S. 754	All	All	All	All	All
H.R. 65	None	None[b]	None[b]	None[b]	None[b]
H.R. 200	[c]	[c]	[c]	[c]	[c]
H.R. 784	None[d]	All	All	All	All
H.R. 1182	All	All	All	All	All
H.R. 1280[e]	All	All	All	All	All
H.R. 1281[e]	All	All	All	All	All
H.R. 1930	$300[f]	All	All	All	All

[a]Administration bill.

[b]With limitations.

[c]The bill requires 20% coinsurance until the beneficiary reaches the $500 coinsurance limit for all services covered by this bill. Eyeglasses and preventive dental care are not covered until the earlier of January 1, 2000, or the first year total expenditures do not exceed 12 percent of the Gross National Product.

[d]For the treatment of chronic illness.

[e]Although we discuss the two bills separately, H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) comprise a legislative package for catastrophic protection. Neither bill provides coverage for medical expenses not currently covered by Medicare.

[f]Beneficiary would have to pay an indexed annual deductible of $300 and a $2 copayment per prescription.

OTHER MEDICAL SERVICES NOT COVERED BY MEDICARE

Definitions

The following medical services are some of the major ones not covered by Medicare:

Routine physical examinations include periodic checkups, preventive laboratory tests, and immunizations.

Outpatient pharmaceutical drugs include drugs--such as antibiotics, analgesics, anti-hypertensive drugs, and insulin--prescribed by physicians for acute and chronic health conditions.

Vision and hearing care includes examinations and fitting of eyeglasses, contact lenses, or hearing aids.

Dental care includes routine diagnostic and preventive services, such as checkups, X-rays, cleaning of teeth, and fillings.

Medicare Coverage

While Medicare part B does not cover the above services, there are some exceptions. For example, part B covers (1) 100 percent of the approved charge for pneumococcal vaccine (even if the $75 deductible has not been met), (2) 80 percent of the approved charge for hepatitis B vaccine for beneficiaries at high or intermediate risk of contracting the disease, (3) 80 percent of the approved charges for immunosuppressive drugs furnished to an organ transplant beneficiary for 1 year after the date of transplant, (4) eyeglasses or corrective lenses prescribed after cataract surgery, and (5) dental care if it involves surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a physician.

Out-of-Pocket Expenses

Medicare beneficiaries are at risk for 100 percent of the charges for noncovered services. Using data from the 1980 National Medical Care Utilization and Expenditure Survey, researchers estimated that for the elderly who had out-of-pocket costs of from $1,001 to $2,000, prescription drugs accounted for 16.2 percent and dental care 12.6 percent of out-of-pocket costs.[19] According to the Congressional Budget Office, almost 5 million Medicare

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[19]Thomas Rice and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," Health Affairs, Vol. 5, No. 3, Fall 1986, p. 16.

beneficiaries spend more than $400 annually on prescription drugs, and for this group, the average annual cost exceeds $900. Current retail prices of hearing aids range from $495 to $1,050 per unit, according to the four firms we contacted. In 1984, 14.5 percent of the elderly had hearing impairments, and of these, over half were hearing impaired in both ears.

Legislative Proposals

Neither S. 1127 nor the administration bills, S. 592 and H.R. 1245, would add coverage to part B for prescription drugs, hearing, vision, dental, or preventive laboratory tests. S. 1127 would, however, allow beneficiaries enrolled in part B to count toward a catastrophic cap specific services not covered by Medicare, including the costs of immunosuppressive drugs for transplant patients after the first year and the costs of certain cancer screening exams. However, H.R. 2470 would add a prescription drug benefit, which would be fully funded by special premium receipts. The beneficiary would pay a separate $500 deductible and be subject to the part B coinsurance of 20 percent.

GAO Comments

Under S. 1127, H.R. 2470 (except for the prescription drug benefits), and the administration bills, Medicare beneficiaries would continue to be liable for out-of-pocket payments for services not currently covered by Medicare. And, except for the costs of immunosuppressive drugs and certain cancer screening exams under S. 1127, those payments would not count toward the catastrophic limits on out-of-pocket payments established by the proposals.

Some of the other legislative proposals have additional provisions that would help the elderly with high out-of-pocket costs for services not currently covered by Medicare. For example, H.R. 65 would add coverage, with limitations, for prescription drugs, hearing aids, vision care, dental care, and preventive laboratory tests with no beneficiary cost sharing, and S. 454 would add coverage for all but prescription drugs, again without cost sharing. H.R. 200 would add coverage for all five services but would impose 20-percent coinsurance subject to the $500 catastrophic cap on all services covered by the bill. H.R. 784 would add coverage of prescription drugs for treatment of chronic illnesses without beneficiary cost sharing, and H.R. 1930 would add a prescription drug benefit that would require the beneficiary to pay an indexed annual deductible of $300 and a $2 copayment per prescription.

Table 6:
Catastrophic Limit on Medicare Beneficiary's Out-of-Pocket Costs for Medicare-Covered Services

	Dollar limit per calendar year
Current Medicare law	No provision in current law
Medigap, maximum out-of-pocket costs	No provision under Medigap requirements

Bill #	First year catastrophic limit[a]	Year effective	Value in 1989
S. 1127	**$1,700[b]**	**1988**	**$1,773[f]**
H.R. 2470	**$1,043 on part B[c]**	**1989**	**$1,043**
S. 592[d]	$2,000[e]	1988	$2,150[f]
H.R. 1245[d]	$2,000[e]	1988	$2,150[f]
S. 210	$2,000[g]	1987	
S. 454	No limit[h]		
S. 754	$1,800[i]	1988	$1,880[f]
H.R. 65	No limit[h]		
H.R. 200	$500[j]	1992	N/A
H.R. 784	No limit[h]		
H.R. 1182	No limit[h]		
H.R. 1280[k]	No limit[h]		
H.R. 1281[k]	$1,000[l]	1988	
H.R. 1930	$500[m]	1989	$ 500

[a]Many of the bills provide for periodic increases to the catastrophic limit.

[b]The catastrophic cap shown is for beneficiaries enrolled in both parts A and B. The cap would include the part A inpatient deductible, hospice coinsurance charges, and coinsurance for the first 10 days of the first 150 days of SNF care each year and part B deductible and coinsurance. Also, two specific services not covered by Medicare would count toward the catastrophic cap, including the costs of immunosuppressive drugs for transplant patients after the first year and the costs of certain cancer screening exams. For beneficiaries enrolled in part A only, there would be no catastrophic cap.

[c]H.R. 2470 established a catastrophic limit for part B deductibles and coinsurance. It would also reduce beneficiary part A expenses by eliminating inpatient coinsurance and reducing the deductibles to one per year and limiting coinsurance during the first 150 days of SNF care each year to 7 days. The part B cap does not apply to the added prescription drug and in-home personal care benefits.

[d]Administration bills.

[e]The catastrophic cap includes the beneficiary out-of-pocket expenses for the inpatient hospital deductible, coinsurance under the hospice benefit, and part B deductibles and coinsurance.

[f]Per CBO estimate.

[g]The catastrophic cap includes the reasonable charges for medical care not paid for by any other government program.

[h]The bill has no catastrophic limit; however, the bill would decrease beneficiary expenses by reducing or eliminating coinsurance or deductibles.

[i]The catastrophic cap includes the beneficiary out-of-pocket expenses for the first inpatient hospital deductible, hospice care coinsurance, part B deductibles and coinsurance, coinsurance in the year after transplant surgery, and reasonable charges for immunosuppressive drugs in subsequent years.

[j]The bill states a $1,500 catastrophic limit. However, according to the bill's sponsor, this was a technical error and should be $500, which would cover beneficiary coinsurance payments for all services covered by this bill.

[k]Although we discuss the two bills separately, H.R. 1280 (which addresses part A) and H.R. 1281 (which addresses part B) comprise a legislative package for catastrophic protection. H.R. 1280 and H.R. 1281, when combined, would decrease beneficiary part A expenses by reducing or eliminating deductibles and coinsurance and would provide a first-year catastrophic limit of $1,000 on part B expenses.

[l]The catastrophic cap includes the beneficiary out-of-pocket expenses for part B deductibles and coinsurance.

[m]The catastrophic cap includes the beneficiary out-of-pocket expenses for any deductibles, coinsurance, or copayments for Medicare-covered part A or part B services, including the new coverage for prescription drugs and respite care.

CATASTROPHIC PROTECTION

Definition

Catastrophic protection sets a maximum amount beneficiaries would have to pay in a calendar year for covered medical services (excluding health insurance premiums). For certain acute illnesses and chronic conditions, the cumulative effect of deductibles, coinsurance, and services not covered by third-party payers can create severe financial hardship.

Medicare Coverage

Medicare has no limit on a beneficiary's out-of-pocket costs for Medicare-covered services.

Out-of-Pocket Expenses

Limited data are available on catastrophic out-of-pocket expenses. In terms of absolute dollars, married couples over age 65 incurred on average about $3,000 in out-of-pocket health care costs in 1986, according to a report prepared for AARP.[20] In terms of health expenditures relative to family income, the report states that the percentage of income spent on out-of-pocket health expenditures increases from an average of about 4 percent for married couples 65 to 69 years old to over 30 percent for married couples 85 years old and over.

Legislative Proposals

Both H.R. 2470 and S. 1127 would set a maximum amount beneficiaries would have to pay in a calendar year for covered medical services with three notable exceptions. Neither bill would limit beneficiary expenses for (1) days of SNF care over the annual maximum of 150 days per year, (2) days of psychiatric care exceeding the lifetime maximum of 190 days, or (3) physician and other charges in excess of Medicare-approved charges for part B services.

H.R. 2470 would place a $1,043 per beneficiary ($2,086 per couple) out-of-pocket cap on Medicare part B expenditures effective in 1989, excluding the new prescription drug and in-home personal care benefits. Although H.R. 2470 does not establish a catastrophic cap on part A expenditures, it limits part A expenditures by eliminating inpatient coinsurance, reducing the inpatient deductibles to one per year, and limiting SNF coinsurance to the first 7 days each year. Effective in 1988, S. 1127 would place a $1,700 per beneficiary ($3,400 per couple) cap on Medicare

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[20] ICF Incorporated, Medicaid's Role in Financing the Health Care of Older Women, Washington, D.C., December 1986, p. 39.

parts A and B expenditures. Additionally, S. 1127 would count specific services not covered by Medicare toward the catastrophic cap, including the costs of immunosuppressive drugs for transplant patients after the first year and the costs of certain cancer screening exams. The administration bills, S. 592 and H.R. 1245, provide for a catastrophic limit of $2,000 for the inpatient hospital deductible, part B deductibles and coinsurance and hospice care coinsurance.

GAO Comments

To the extent that the elderly incur high out-of-pocket costs for deductibles and coinsurance for part A and part B covered services, they would benefit from a fixed limit on out-of-pocket costs. According to a December 1986 article in Health Affairs, a disproportionately large percentage of families headed by an individual over 65 years old incurred high out-of-pocket costs relative to income.[21] Catastrophic protection based on a fixed limit may not adequately alleviate the financial burden borne by the lower income elderly who spend a high percentage of their income on health expenses.

Furthermore, over 81 percent of the expenses of the elderly with out-of-pocket costs in excess of $2,000 were for nursing home care. Most nursing home costs are not covered by Medicare because its coverage is directed at acute skilled care and it does not cover intermediate and custodial care. These costs, therefore, could not be applied toward the catastrophic cap except under H.R. 200, which adds intermediate and custodial care with 20-percent coinsurance. S. 454 and H.R. 65 would also relieve beneficiaries of these expenses by adding intermediate and custodial care coverage. In addition, the burden of expenses for other noncovered services, including prescription drugs, preventive services, hearing aids, and dental care, would not be alleviated by the maximum limits established in the proposals.

Finally, the literature uses family income to analyze catastrophic expenses. Typically, resources that are used to pay for health care expenditures are pooled at the family level. The caps proposed in the bills, in contrast, are established on a per beneficiary basis. As a result, a husband and wife may be responsible for out-of-pocket expenses amounting to as much as two times the catastrophic limit if they both incur medical expenses.

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[21]Leon Wyszewianski, "Families with Catastrophic Health Care Expenditures," Health Affairs, Vol. 21, No. 5, December 1986, p. 623.

FINANCING AND COSTS

The current Medicare part A and part B programs are financed separately. Part A is financed primarily through a compulsory payroll tax under the Federal Insurance Contributions Act. Under the act, equal payments are made by employers and employees. The self-employed also pay this tax. In addition, persons who are not entitled to part A benefits can pay a premium of $226 per month (in 1987) for part A benefits. These monies are earmarked for the part A trust fund to pay benefits and administrative expenses. Part B, which is optional, is financed by general revenues and premiums paid by or on behalf of those who elect coverage. In 1987, the part B monthly premium is $17.90. Current law provides that, between 1984 and 1988, premiums pay for 25 percent of benefits and administrative costs, and general revenues finance the remainder. For calendar years beginning in 1989, the calculation of the part B premium will be the lower of (1) an amount sufficient to cover one-half of the costs of the program for the aged or (2) the current premium amount increased by the percentage by which cash benefits were increased under the cost-of-living adjustment provisions of the Social Security program.

Several financing mechanisms were proposed in the bills we reviewed, including increased beneficiary part B premiums, increased income taxes for the elderly, increased payroll taxes, higher coinsurance charges, earmarked revenues from a tax on cigarettes, general revenues, or combinations of these. Both S. 1127 and H.R. 2470 would raise flat part B premiums and also raise revenue by adding new supplemental income-related premiums. Only the administration proposal would finance the catastrophic coverage exclusively with flat premiums.

H.R. 2470 would also transfer all home health benefits to part B, except that individuals enrolled in part A only would continue to be eligible for home health benefits under part A. Therefore, almost all home health benefits would be financed by part B premiums and general revenues. As under current law, the 20-percent coinsurance rate and $75 deductible would not apply to part B home health services.

Both H.R. 2470 and S. 1127 would increase flat premiums. H.R. 2470 would increase flat premiums in 1989 by up to $2.60 monthly for the new prescription drug and in-home care benefits. Additionally, under H.R. 2470, ad hoc monthly premium increases of $1.00 and $1.30 would be made in 1991 and 1992, respectively. S. 1127 would add a $4.00 monthly flat premium in 1988 indexed to the per-enrollee value of catastrophic benefits.

In addition, both bills would levy new income-related premiums. Under H.R. 2470, all taxpayers eligible for part A with adjusted gross income over $6,000 would begin paying a supplemental income-related premium in 1988 ranging from $10 to $580 through the

income tax system. Under S. 1127, part B enrollees with income tax liabilities of $150 or more would begin paying a supplemental income-related premium of $12.24 for each $150 of tax liability (in 1988) up to a maximum liability of $800 per enrollee. Beginning in 1992, S. 1127 would require that premiums be set to fully cover the costs of new benefits provided under the bill each year.

According to Congressional Budget Office estimates, about 81 percent of new premiums raised under H.R. 2470 would be income-related, while 19 percent would be flat. In contrast, about 57 percent of the premiums raised under S. 1127 would be income-related and 43 percent would be flat. Moreover, beneficiaries could opt out of part B benefits, expanded catastrophic coverage and premium increases under S. 1127 by disenrolling from part B. Under H.R. 2470, however, although the new flat premiums could be avoided by disenrolling from part B, the income-related portion of the new premium would be paid by all those eligible for part A benefits. This mandatory supplemental premium is intended to avoid the potential adverse selection problem--withdrawal from the program by the healthier Medicare beneficiaries. The effect of adverse selection could be to increase the per enrollee cost of Medicare and thus require increases in the supplemental premium to retain budget neutrality.

According to the Congressional Budget Office, the automatic financing mechanisms included in S. 1127 and H.R. 2470 are not designed to generate sufficient premiums to cover the costs of new Medicare benefits in every year without ad hoc premium increases. H.R. 2470, however, does provide for two ad hoc premium increases, which would generate sufficient premiums to cover costs, at least through 1992.

Table 7 presents the Congressional Budget Office 5-year projections for additional Medicare costs and premium receipts. The H.R. 2470 plan, totaling $32.4 billion over the 5-year period, would be the most expensive. For the same period, the S. 1127 plan would cost $22.1 billion. H.R. 2470 would generate a surplus of $1.9 billion over the 5-year period, including the two ad hoc premiums provided for in the bill. Under S. 1127, there would be a shortfall of $560 million over the 5-year period without ad hoc premium increases.

Table 7: Medicare Benefit Costs and Receipts (1988-92)
(Fiscal year outlays, in millions of dollars)

Proposal	1988	1989	1990	1991	1992	Total 1988-92
H.R. 2470:						
Medicare benefits	1,050	4,790	7,445	8,945	10,155	32,385
Administrative Costs	156	186	182	187	192	902
Premiums:						
Flat Premiums[a]	10	-775	-1,435	-2,055	-2,280	-6,535
Income-Related	-1,420	-5,170	-6,450	-7,375	-8,265	-28,680
Total	-205	-970	-258	-298	-198	-1,928
S. 1127						
Medicare benefits	1,385	3,510	4,825	5,715	6,665	22,100
Administrative Costs	69	24	24	24	24	165
Premiums:						
Flat Premiums	-760	-1,685	-1,945	-2,285	-2,655	-9,330
Income-related	-660	-2,300	-2,660	-3,135	-3,620	-12,375
Total	34	-451	244	319	414	560

[a]Includes outlay-based part B premiums, ad hoc part B premiums, and change in part A premium calculation.

Source: U.S. Congressional Budget Office.

According to the Congressional Budget Office, benefits per enrollee would increase by 7 percent relative to current law under H.R. 2470 and by 4 percent under S. 1127. These increases reflect, in large part, a transfer of copayment and drug costs currently borne by enrollees to the Medicare program. Both bills would benefit lower income groups, who would pay a disproportionately small share of the costs relative to the benefits they would receive. Specifically, the S. 1127 financing mechanism would result in the poor paying 4.5 percent of the costs and receiving more than 16 percent of the benefits. Under H.R. 2470, the poor would pay only 1.6 percent of the costs and receive 15 percent of the benefits.

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